Maryland Diabetes Medical Management Plan/ Health Care Provider Order Form

Valid from: Start ___/___/___ to End ___/___/___ or for School Year _____

MARYLAND STATE DEPARTMENT OF EDUCATION
EQUITY AND EXCELLENCE

MARYLAND Department of Health

Demographics			
Student Name:	DOB:	Grade:	Diagnosis:
Parent/Guardian:	Home Phone:	Work Phone:	Cell Phone:

Insulin Orders

Insulin Dosing:

□ Carbohydrate coverage □ Correction dose only □ Correction dose plus CHO coverage □ Fixed dose □ Fixed dose with correction scale □ See attached dosing scale

Insulin(s):

□ **Rapid Acting:** □ Apidra □ Humalog □ Novolog □ Admelog □ Other (specify): _____

□ Any of the **rapid acting** insulins may be substituted for the others

□ **Long Acting** (if given at school): _____ Give _____ unit(s) of insulin Sub-Q at _____ (time)

Insulin Delivery: □ Pen □ Syringe □ Pump (make/model):

Carbohydrate (CHO) Coverage per meal: □ _____unit(s) of insulin Sub-Q per ____ grams of CHO at breakfast

□ _____unit(s) of insulin Sub-Q per ____ grams of CHO at lunch □ ____ unit(s) of insulin Sub-Q per ____ grams of CHO at dinner

Carbohydrate Dose Adjustment Prior To Strenuous Exercise Within _____ Minutes:

□ Use exercise/PE CHO ratio of ____ unit(s) of insulin per ____ grams of CHO at breakfast

□ Use exercise/PE CHO ratio of ____ unit(s) of insulin per ____ grams of CHO at lunch

□ Use exercise/PE CHO ratio of ____ unit(s) of insulin per ____ grams of CHO at dinner

Correction Dose: □ Give ____ unit(s) of insulin Sub-Q for every ____ mg/dl greater than BG of _____ mg/dl

□ If pre-breakfast BG less than ____ mg/dl, subtract ____ unit(s) of insulin dose

□ If pre-lunch BG less than ____ mg/dl, subtract ____ unit(s) of insulin dose

□ If pre-dinner BG less than ____ mg/dl, subtract ____ unit(s) of insulin dose

□ **Fixed Dose Insulin:** ____ unit(s) of insulin Sub-Q given before school meals

□ **Split Insulin Dose**:

Give ____ unit(s) or ____% of meal insulin dose Sub-Q before meal and ____ unit(s) or ____% of meal insulin dose Sub-Q after meal

Snack Insulin Coverage: □ No snack coverage □ Snack coverage if BG > ____ mg/dl

□ ____ unit(s) of insulin Sub-Q per ____ grams of CHO

Insulin Dose Administration Principles

*See page 2 for Hyperglycemia management

Insulin should be given:

□ Before meals □ Before snacks □ Other times (please specify):

□ For correction if BG > _____ mg/dl and _____ hours since last dose/bolus

□ If CHO intake cannot be predetermined, insulin should be given no more than _____ minutes after start of meal/snack

□ If parent/guardian requests, insulin should be given no more than _____ minutes after start of meal/snack

□ Use pump or bolus device calculations per programmed settings, once settings have been verified

□ Parent/Guardian has permission to increase/decrease insulin correction dose by +/- one (1) unit to three (3) units

Independent Insulin Administration Skills & Supervision Needs*

*Skills to be verified by school nurse

□ Insulin dose calculations	□ Carbohydrate counting	□ Measuring insulin	□ Insulin administration
□ Independent □ With Supervision	□ Independent □ With Supervision	□ Independent □ With Supervision	□ Independent □ With Supervision

Other Diabetes Medication

Name of Medication	Time	Dosage	Route	Possible Side Effects

Authorizations

HEALTH CARE PROVIDER AUTHORIZATION

I authorize the administration of the medications and student diabetes self-management as ordered above.

Provider Name (PRINT):

Phone: **Fax:**

Provider Signature: **Date:**

PARENT/GUARDIAN AUTHORIZATION

By signing below, I authorize:

- The designated school personnel to administer the medication and treatment orders as prescribed above.

By signing below, I agree to:

- Provide the necessary diabetes management supplies and equipment; and
- Notify the nurse of any changes in my child's care or condition.

Parent/Guardian Signature: **Date:**

Acknowledged and received by: **School Nurse:** **Date:**

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Blood Glucose Monitoring* *Self-management skills to be verified by school nurse

Blood Glucose (BG) Monitoring:

□ Before meals □ Before PE/Activity □ After PE/Activity □ Prior to dismissal □ Additional monitoring per parent/guardian request

□ For symptoms of hypo/hyperglycemia & anytime the student does not feel well □ **Student may independently check BG***

Continuous Glucose Monitoring

□ Uses CGM Make/Model:

Alarms set for: **Low _____ mg/dl** **High _____ mg/dl** □ **If sensor falls out at school, notify parent/guardian**

Hypoglycemia Management* *Self-management skills to be verified by school nurse

<u>Mild or Moderate Hypoglycemia</u> (BG below _____ mg/dl)

□ **Provide quick-acting glucose product equal to 15 grams of carbohydrate (or glucose gel), if conscious & able to swallow.**

□ Suspend pump for BG < _____ mg/dl and restart pump when BG > _____ mg/dl

□ Student should consume a meal or snack within _____ minutes after treating hypoglycemia

□ Other: _____

Always treat hypoglycemia before the administration of meal/snack insulin

Repeat BG check 15 minutes after use of quick-acting glucose

- If BG still low, re-treat with 15 grams quick-acting CHO as stated above
- If BG in acceptable range and it is lunch or snack time, have student eat and cover meal CHO per orders
- If CGM in use and BG ≥70 mg/dL and arrow going up, no need to recheck

Student may self-manage mild or moderate hypoglycemia and notify the school nurse*: □ **Yes** □ **No**

<u>Severe Hypoglycemia</u> (includes any of the following symptoms):

- Unconsciousness
- Inability to swallow
- Semi-consciousness
- Seizing
- Inability to control airway
- Worsening of symptoms despite treatment/retreatment as above

□ **GLUCAGON** injection: □ 1 mg □ 0.5 mg IM or Sub-Q

- Place student in the recovery position
- Suspend pump, if applicable, and restart pump at BG > _____ mg/dl
- Call 911 and state glucagon was given for hypoglycemia; notify parent/guardian

□ **If glucagon is not available or there is no response to glucagon, administer glucose gel inside cheek, even if unconscious or seizing. If glucose gel is administered, place student in recovery position.**

Hyperglycemia Management* *Self-management skills to be verified by school nurse

If BG greater than _____ mg/dl, or when child complains of nausea, vomiting, and/or abdominal pain, check urine/blood for ketones.

If urine ketones are **<u>trace to small</u>** or blood ketones _____mmol/L:

- Give _____ ounces of sugar-free fluid or water per hour as tolerated
- Give insulin as listed in insulin orders **no more than every _____ hour(s)**

If urine ketones are **<u>moderate to large</u>** or blood ketones greater than _____ mmol/L

- Give _____ ounces of sugar-free fluid or water per hour as tolerated
- If student uses pump, disconnect pump
- Give insulin as listed in insulin orders **no more than every _____ hour(s) by injection**

If large ketones and vomiting or large ketones and other signs of ketoacidosis, call 911. Notify parent/guardian.

Recheck BG and ketones _____ hours after administering insulin

Contact parent/guardian for: □ BG > _____mg/dl □ Ketones _____ mmol/L

Student may self-manage hyperglycemia with trace/small ketones and notify the school nurse:* □ **Yes** □ **No**

Ketone Coverage

For ketones <u>trace to small</u> (urine)/<_____ mmol/L (blood)
□ Correction dose plus ____ unit(s) of insulin
□ ____ unit(s) of insulin

For ketones <u>moderate to large</u> (urine)/>_____ mmol/L (blood)
□ Correction dose plus ____ unit(s) of insulin
□ ____ unit(s) of insulin

Parent/Guardian Name:	**Signature:**	**Date:**
Provider Name:	**Signature:**	**Date:**

Acknowledged and received by:	**School Nurse:**	**Date:**

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Physical Education, Physical Activity, and Sports *Self-management skills to be verified by school nurse

□ Avoid physical education/physical activity/sports if:
- □ BG < _____ mg/dl
- □ BG > _____mg/dl
- □ Trace/small ketones present
- □ Moderate/large ketones present

□ If BG is ≤ _____ mg/dl, give 15 grams of CHO and return to physical education/physical activity/sports
□ May disconnect pump for physical education/physical activity/ sports
□ Student may set temporary basal rate for physical education/physical activity/sports*
□ Other:

Transportation *Self-management skills to be verified by school nurse

□ Check BG prior to dismissal
- □ If BG is not > _____ mg/dl, give _____ grams carbohydrate snack
- □ BG must be > _____ mg/dl for bus ride/walk home

□ Only check BG if symptomatic prior to bus ride/walk home
□ Allow student to carry quick-acting glucose for consumption on bus, as needed for hypoglycemia*
□ Student must be transported home with parent/guardian if (specify): _____
□ Other:

Disaster Plan (if needed for lockdown, 72 hr shelter in place)

□ Continue to follow orders contained in this medical management plan
□ Additional insulin orders as follows:
□ Other:

Pump Management

Type of Pump: Pump start date: Child Lock: □ On □ Off

Basal rates:

___ unit(s)/hour	___ AM/PM	___ unit(s)/hour	___ AM/PM
___ unit(s)/hour	___ AM/PM	___ unit(s)/hour	___ AM/PM
___ unit(s)/hour	___ AM/PM	___ unit(s)/hour	___ AM/PM

Additional Hyperglycemia Management:
□ If BG > _____ mg/dl and has not decreased over _____ hours after bolus, consider infusion site change. Notify parent/guardian
□ For infusion site failure: □ Give insulin via syringe or pen □ Change infusion site
□ For suspected pump failure, suspend or remove pump and give insulin via syringe or pen
□ If BG > ___ mg/dl and moderate to large ketones, student should change infusion site and give correction dose by pen or syringe
□ Comments:

Independent Pump Management Skills and Supervision Needs*
*Skills to be verified by school nurse. Supervision will be provided if not fully independent when appropriate

Student is independent in the pump skills indicated below:

□ Carbohydrate counting	□ Bolus an insulin dose	□ Set a basal rate/temporary basal rate
□ Reconnect pump at infusion set	□ Prepare and insert infusion set	□ Troubleshoot alarms and malfunctions
□ Give self-injection if needed	□ Disconnect pump	□ Other:

Additional Orders

□ Please FAX copies of BG/insulin diabetes management records every _____ weeks (FAX number:)

□ Other orders:

Parent/Guardian Consent for Self-Management

- I acknowledge that my child ☐ **is** ☐ **is not** authorized to self-manage as indicated by my child's health care provider.
- I understand the school nurse will work with my child to learn self-management skills he/she is not currently capable of or authorized to perform independently.

My child has my permission to independently perform the diabetes tasks listed below as indicated by my child's health care provider:

□ Blood glucose monitoring	□ Insulin administration	□ Pump management
□ Carbohydrate counting	□ Insulin dose calculation	□ Other:

Parent/Guardian Name:	**Signature:**	**Date:**
Provider Name:	**Signature:**	**Date:**

Acknowledged and received by:	**School Nurse:**	**Date:**